DOCUMENT RESUME

ED 473 278 CG 032 237

AUTHOR	Choudhuri, Dibya
TITLE	Multicultural Clients in Counseling: A Review of the Literature.
PUB DATE	2003-00-00
NOTE	42p.
PUB TYPE	Information Analyses (070)
EDRS PRICE	EDRS Price MF01/PC02 Plus Postage.
DESCRIPTORS	Acculturation; *Client Characteristics (Human Services); Counseling; *Counselor Client Relationship; *Cultural Awareness; *Ethnicity; Mental Disorders; *Racial Identification
IDENTIFIERS	*Multicultural Counseling

ABSTRACT

This paper reviews a selection of the recent literature on issues pertaining to multicultural clients in counseling, focusing on the current demographics of such populations, the prevalence of mental illness and utilization of mental health services, and particular cultural concerns in working with such populations, including aspects of acculturation and racial identity development. Finally, this review surveys the research on aspects of the counseling relationship, with attention paid to the impact of ethnicity on the formation and development of the counseling relationship. (Contains 77 references.) (Author)

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CG CG TR 0024

ED 473 278

Multicultural Clients in Counseling: A Review of the Literature

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Abstract

This paper reviews a selection of the recent literature on issues pertaining to multicultural clients in counseling, focusing on the current demographics of such populations, the prevalence of mental illness and utilization of mental health services, particular cultural concerns in working with such populations including aspects of acculturation and racial identity development. Finally, this review surveys the research on aspects of the counseling relationship, with attention paid to the impact of ethnicity on the formation and development of the counseling relationship.

Multicultural Clients in Counseling: A Review of the Literature

Introduction

The literature on multicultural clients approaches the central issue of their participation and experience in counseling in a variety of ways and is vast and sprawling. The first step is to arrive at a definition of the client populations that this review will focus on as well as a brief overview of the varying nomenclature used in the field.

According to the National Institute of Mental Health, the American Psychological Association, and the American Counseling Association, African Americans, Native Americans, Latinos, and Asian Americans, all deserve special attention for both their racial/ethnic memberships in sub-groups of society, as well as the particular history of restriction in terms of education, economic, and political opportunities from full and equal participation in the life of the society (Ponterotto & Casas, 1995). Different terms used in the literature that collectively describe members of these groups include minorities (Ponterotto & Casas, 1991), the culturally different (Sue, 1981), ethnic minorities (Aponte and Crouch, 2000), non-whites (D'Andrea, 1995), people of color (Ivey, 1995) or ALANA (Helms & Cook, 1999). Where possible, in this review, I will seek to use the specific terminology for each group, (e.g. African American or Black, Haitian American, Jamaican American) and if describing general research about these groups collectively, will use the term ALANA to denote the experience of these persons who collectively comprise people of African, Latino, Asian and Native heritage, identifying solely the categorization of research based on membership in specific ethnic groups.

Reflecting on the issues of multicultural clients, it first becomes important to identify them, apart from their status as clients, to be able to ground their experience in counseling. Accordingly, this review will start with a discussion of the demographics and sociopolitical history of people of ethnic minority groups in the US. After covering basic information about multicultural groups, the epidemiology of prevalence of mental illness and utilization of mental health services will be outlined. Since the cultural frameworks that impact the worldviews of ALANA clients and their utilization of counseling is crucial, the next part of the review will cover important topics in the literature such as acculturation and racial and ethnic identity development. Given that the narrative experience of multicultural clients is the focus of this study, a brief is warranted. Following a brief exploration of perspectives on the counseling relationship, the available literature on ALANA groups in terms of help-seeking behavior, and specific counseling issues that arise such as acculturation, ethnic and racial identity development, counselor preferences, and client perspectives will be surveyed.

Demographic profiles

According to the U.S. Bureau of Census (1997), in terms of percentages of the total population, 12.6% are African Americans, 10.2% are Hispanics, 3.6% are Asian and Pacific islanders, with 0.9% being Native American and Alaskan Natives. While this represents only a small change from 1990 figures, dramatic changes are anticipated by the year 2050, with the non-Hispanic White population falling steadily from 72% in 2000 to about 53% in 2050 (U.S. Bureau of Census, 1997). Some part of the rapid increase in ethnic groups other than Whites is through immigration, since almost a million new

persons are added to the population every year, making 1 in 11 Americans born in an other country. Another rise is due to the rising birthrate among many of the groups, with Latinos having the highest birth rate while Native Americans and Alaskan Natives also maintain high birth rates.

One way to think about the ALANA populations of the US is to divide them into five categories based on migration and choice. *Sojourners* are temporarily present and comprise people such international students, diplomats, and temporary workers, and have temporary cultural contact with the society. *Immigrants* are migratory in having relocated from another society and are considered relatively voluntary. Refugees, on the other hand, are migratory but relatively involuntary. *Ethnic groups* are nonmigratory and more or less willingly interact with the larger society of their choosing, while maintaining affiliation with a defined group within the society. Finally, *Native peoples* are indigenous to the region, nonmigratory and involuntary in their presence (Berry & Kim, 1988). Such a categorization does not however take account of specific histories such as that of Afrcan-Americans who are descendants of Africans forcibly enslaved. While being considered currently members of ethnic groups, their original presence here was involuntary.

Ethnic Groups. Among the various groups in the US, Asian Americans straddle the first four categories, from temporary sojourner, through immigrant, refugee, and ethnic group members who have a multigenerational presence in the US. This diversity makes general discussions about Asian and Pacific Islanders as the Census groups them, difficult to say the least. In the 1990 U.S. Census there were 29 Asian groups enumerated while the 2000 Census will have 11 different categories to replace the

singular Asian/Pacific Islander category (U.S. Bureau of Census, 1997). Hispanics, another group label by the Census, also come from many different countries and reflect a variety of migratory waves, including Chicanos indigenous to the Southwest. African Americans constitute those who can trace their ancestry to Africa, but comprise both descendents of enslaved Africans forcibly brought to this country, as well as African immigrants and immigrants from the African-originated Caribbean populations. Finally, while Native Americans and Alaskan natives or Aleuts are all considered indigenous peoples, they also comprise over 200 tribes, speaking different tribal languages, with different specific histories with the US Government, reservations, and relocation experiences. However, a central commonality is that of being indigenous to this continent, having a common legacy of conquest and a sociopolitical experience of genocide and continuing oppression.

Locations. The majority of African Americans tend to live in urban areas, with about half the population in the South, and the rest split between the Midwest, Northeast and West. The various Latino groups have been geographically distributed in areas consistent with their point of entry. Thus, while the Northeast has high concentrations of Puerto Ricans particularly in the New York metropolitan region, Mexican Americans cluster in California and Texas, and Cuban Americans are concentrated in Florida. Asian Americans historically have been concentrated in the West, with over half the population residing there. While Asians also live primarily in urban areas, they also tend to live in less segregated neighborhoods than do African Americans. Finally, about half of all Native Americans appear to reside in the West, and about one-third live in the South,

while Eskimos and Aleuts mostly cluster in the Alaskan peninsula and the Aleutian Islands (U.S. Dept. of Commerce, 1997, in Aponte and Crouch, 2000).

Age and mortality. According to the U.S. Census (U.S. Bureau of Census, 1997), ALANA groups have a younger median age than Whites. The youngest compared to the overall U.S. population, Hispanics had a median age of 26.3 years, while the median age of African Americans was 29.2. Asian Americans fell between African Americans and Whites with a median age of 30.6 years, with Whites the oldest age of 36.6 years. Another difference between Whites and ALANA groups is mortality rates. The most significant are the differences between African American and White life expectancy rates with Whites having an average of 7 years more than African Americans. The reasons cited for this difference for African Americans include the greater infant mortality rates, the higher death rates from a number of illnesses, and homicide as a leading cause of death for young African American men. (National Center for Health Statistics, *1991).*

Family structure and living arrangements. Household size also varies with ethnic groups, on average, having larger households than Whites. In comparison to 2.5 persons in a White household, African Americans had 2.9 persons, Native Americans had 3.1 persons, Asian Americans had 3.4, and Latino households had 3.6 (O'Hare, 1992). Most ALANA households were more likely to include other adults in addition to a married couple, and Asian American families in particular were more than twice as likely to live in extended families. In other changes, while the divorce rate has increased, the numbers of women of color who had never married increased, with African American women at 42% over double the rate of unmarried White women at 19% (O'Hare, 1992). African

American, Native American, and Latina women also headed up the numbers of female-headed households at 47%, 28.7%, and 22.2 % respectively (U.S. Bureau of Census, 1997).

Socioeconomic status. The key variables viewed in making some determination of socioeconomic status (SES) include occupational status, income and education. While all ethnic groups in each of these areas have made gains, there is still a significant lag behind Whites in the types of jobs obtained, the income earned, and the educational levels achieved (O'Hare, 1992). While 27% of Whites were in white-collar professions and 14.2% were in semi-skilled labor, only 16.5% of African Americans had professional and managerial positions as contrasted to 22.9% in semiskilled labor (U.S. Bureau of Census, 1997). Hispanics tended to have a diverse labor market experience dependent on the migration history, as well as education, training, and English language skills. So, Cuban Americans and U.S. born Latinos were more likely to have white-collar jobs, while over all as a group, Hispanics tended to be found in lower-paying, more unstable and hazardous occupations than non-Hispanics. (Aponte and Crouch, 2000).

Asian Americans also mask internal differences, so that while Asian Americans have, on the whole, similar percentages of high-level occupations as Whites, more than 20% of Vietnamese and Southeast Asian Americans work in low or unskilled positions (Lee, 1998). Native Americans resemble African Americans in the higher occupational categories and Hispanics at the lower levels (O'Hare, 1992), with a 38.7% concentration in semiskilled and service positions. Overall, the high concentration of ALANA group members in lower-level occupations has a direct bearing on the career opportunities available and on individual and family income.

While income levels rose across the board as a result of the improved U.S. economy, some of the optimism was misleading, since while overall household income rose relative to that of Whites, there tend to be more members per household in these groups than in White households (O'Hare, 1992). According the 1998 U.S. Census figures, Asian and Pacific Islanders had the median household income ($45, 249), followed by Whites ($38, 972), Hispanics ($26, 628) and African Americans ($25, 050) (in Aponte and Crouch, 2000). Income levels for Asian American households however may be framed by residence and immigration status. Since many live in high-cost urban areas, their living expenses may be correspondingly high. Recent immigrants from China, Laos, Thailand, and Cambodia also tend to earn lower incomes than those born in the U.S. (Lee, 1998). At the same time, all ALANA groups have higher rates of poverty than do Whites, with dramatic levels of poverty for those ALANA persons under the age of 18 (O'Hare, 1992).

In terms of education attainment, both African Americans and Latinos have experienced gains, though as a group, African Americans, Latinos, and Native Americans are still more likely than whites to have less than a high school education (O'Hare, 1992). Asian Americans have almost identical rates of education than Whites, though again, differences exist between recent immigrants and U.S. born Asians (Lee, 1998). Young people of ALANA populations, particularly African American, Latino, and Native American groups, tend to drop out of school early and limited skills to compete in the job market, ending up with positions in the service sector for minimum wages. African American youth have unemployment rates nearly twice those of their White counterparts (U.S. Bureau of Census, 1997).

The rising numbers of ALANA groups indicates an increasing demand for mental health services, which in turn means that more providers will need to know how to deal with ALANA client populations in terms of assessment, intervention, and counseling strategies. The increasing number of immigrants will also tax the mental health system with unique challenges of impoverishment, pre-migration trauma, post-migration adjustment, language and cultural characteristics. The type of mental health services offered will also need to become sensitive to the issues of the relative youth and poverty of ALANA groups as compared to Whites. In addition to the struggles around ethnic identity, discrimination, and oppression, ALANA group members may also present with certain problems that have a greater impact. The high rates of AIDS among African American and Hispanic men and women, the rates of substance abuse among Native Americans and African Americans, and the trauma of experiences among Vietnamese, Cambodian, or Salvadoran refugees all require attention from counselors. The next section of the literature review will examine specifically the incidence of mental illness and utilization of services by ALANA groups in the US.

Prevalence of mental illness and utilization of mental health services

Research into the use of mental health services gives equivocal answers. On the one hand, various studies have found that African Americans and Native Americans tend to overutilize mental health services, while Asian Americans and Latinos tend to underutilize (Kurasaki, Sue, Chun & Gee, 2000) regardless of outpatient or inpatient setting or service facility. However, in a national survey of African Americans, Neighbours (1985, in Kurasaki et al., 2000) found that only a small number reported that

they used mental health services for psychological problems. Similarly confusing, Rogler et al. (1989) found that Puerto Ricans in New York City had higher utilization rates than did non-Latino Whites. Kurasaki et al. (2000) caution that the patterns of utilization may change over time and different groups may have low use because of low prevalence of disorders or high use because of high prevalence.

Investigators' speculations about these utilization rates have included explanations of differences in socioeconomic status, rates of psychopathology, help-seeking tendencies, cultural variable, minority status, diagnostic and assessment bias, as well as structural barriers. African American and Latino clients, for instance, appear to have significantly briefer stays in psychiatric inpatient facilities, while the recidivism rate is much higher. The conclusion drawn from this data by Manderscheid and Sonnenschein (1990) was that such clients seemed to be discharged prematurely only to be returned frequently. According to Korchin (1980), while ALANA clients are more likely to receive diagnoses of serious mental illness with poor prognoses, they are less likely to receive psychotherapeutic services and more likely to receive pharmacotherapy treatment. This implies that mental health professionals are more enthusiastic about medicating such clients as to counseling them. Other explanations might be that ALANA clients may reject counseling or dropout if their needs are not met. While all these explanations are plausible, Turner and Kramer (1995) cite other research that demonstrates that ALANA counselors were significantly more likely to report having ALANA clients than were White counselors.

When Keith, Regier, and Rae (1991) examined the apparently high rate of psychiatric disorders among African Americans, they found that allowing for

socioeconomic factors removed most of the difference in prevalence. In other words, being poor was a greater variable in being at risk for a psychiatric disorder than being African American per se. However, Snowden and Cheung (1990) found that while African Americans were underrepresented in the use of outpatient psychiatric facilities, it depended on the services offered, type of provider, and the source of payment. Individual outpatient care that was paid for either by fee-for-service arrangements or by managed care showed the least amount of usage by African Americans. This difference among primarily working and middle-class African Americans implies that socioeconomic status alone cannot account for discrepancy in use (Snowden, 1998b).

Asian Americans are distinguished by having the lowest levels of seeking care, being only a quarter as likely as Whites, and half as likely as African Americans and Latinos (Lee, 1998). They were also less likely than Whites to be psychiatric inpatients. This underutilization has been theorized as being due to a combination of factors, including stigma and loss of face over mental illness, different cultural explanations for illness, limited English proficiency among some recent immigrants, as well as the inability to find culturally competent services (Sue et al., 1994).

Interestingly, Latinos have similar rates of mental illness to Whites when examined over a long time (Robins & Regier, 1991, in Regier, 1993). A study by Vega and Murphy (1990) found that Mexican Americans born in the US had similar rates of mental disorders to Whites, while Mexican Americans who had immigrated had lower rates. However, studies also show that Mexican American women and Puerto Rican women with depression are often underrepresented in counseling services and over-represented in general medical services (Jimenez, 1997).

Few widespread surveys have been done on Native American and Alaskan native populations, and what survey data there is may be biased (Herring, 1999). For instance, the widely-quoted Indian Health Service data cannot be considered to be representative of all Native Americans as claimed, since the Service recognizes only those peoples living on 32 reservations in the US, and does not include data from Native peoples in urban areas or other reservations (Paniagua, 1994, in Herring, 1999). However, some general conclusions include the substantive prevalence of alcohol and substance abuse, at twice the rate found in any other population, as well as the extremely high rate of suicide (Indian Health Service, 1998). Similar to African Americans, Native Americans are also over-represented among inpatient psychiatric facilities and underrepresented in outpatient care (Snowden and Cheung, 1990).

Another method of determining the effectiveness of mental health services with ALANA clients has been to look at the length of treatment with the assumption that effective counseling engages clients while ineffective counseling causes premature termination. While in one study, African Americans, Asian Americans, Native Americans and Latinos appeared to have significantly higher dropout rates than did Whites (Sue, 1977, in Sue, 1994), on another study, only African Americans had a high drop out rate (Sue et. al, 1991, in Sue, 1994). However, in this study two factors were found to be related to the numbers of sessions across groups: being poorer and having an ethnically dissimilar therapist predicted a lower number of treatment sessions.

Examining effectiveness of treatment in terms of the improvement in clients shows inconclusive results. The treatment outcomes of African Americans were poorer than the outcomes of Whites (Brown, Joe, & Thompson, 1985) while in no study were

the outcomes of African Americans superior to those of any other group (Sue, 1994). Counseling with Native Americans has tended to focus on treatment programs for substance abuse, and research has tended to follow suit. One study by Query (1985) found that in comparing adolescent Native Americans and Whites in an inpatient chemical dependency program, treatment appeared to be more effective with the Whites. Prevention programs appear to be more successful, but the lack of research allows for few conclusions to be drawn (Sue, 1994).

The picture is somewhat more complicated with Asian Americans. Zane (1983, in Kurasaki et al., 2000) found significant improvement of Asian American clients after psychotherapy, on both clients as well as therapist outcome measures. Kinzie and Leung (1989) found that pharmacotherapy and psychotherapy combined to produce positive treatment outcomes among Southeast Asian Americans. However, Asian American clients were much less satisfied with both services and progress than were Whites (Zane, 1983). Asian Americans also tend to rate both the counseling experience and the counselors as less effective (Sue, 1981).

Treatment outcome research with Latino clients tend to have focused on examining the effects of culturally sensitive programs. Rogler, Malgady, and Rodriguez (1989) examined research that suggested that having such programs increases service utilization, length of treatment, and client satisfaction with treatment. Some of the strategies evaluated included having bicultural or bilingual staff, modifying or developing therapies that were congruent with Latino cultural values and norms, increasing the participation of family members, religious leaders or indigenous healers (Rogler, Malgady, & Rodriguez, 1989). There is some research that ethnic matching between

client and counselor, especially among Mexican American clients leads to more positive outcomes (Lopez, Lopez & Fong, 1991) though this may be an initial preference.

The reluctance of ALANA clients to seek help from counseling has been best documented in research with African Americans. Reasons given by such clients for not seeking professional help include lack of time, fear of hospitalization, and fear of treatment (Sussman, Robins & Earls, 1987). This mistrust appears to be generated from the history of racism that such clients have experienced (Priest, 1991). This lack of trust is likely to occur among other ALANA clients, according to research of attitudes towards government and institutions rather than mental health services per se. Recent immigrants who may have undocumented relatives, refugees with a history of being persecuted by their governments such as Salvadoran or Cambodian refugees, or Native Americans who have experienced historical betrayal and forced control from the US Government, may all be disinclined to seek help from such suspect institutions (Herring, 1999).

The stigma of mental illness may be another barrier to help seeking. While both African Americans and Whites report embarrassment as a major factor in disallowing the seeking of help (Sussman et al., 1987), African Americans tend to deny the threat of mental illness and strive to overcome issues through self-reliance (Snowden, 1998b). Cultural factors tend to encourage the use of family, social supports, and traditional sources of care. Lin, Tardiff, Donetz, and Goresky (1978, in Draguns, 2000) developed a typology of pathways to seeking help. In Type A, the family strives to find a solution for the problems experienced by one of its members and then turns to a medical practitioner rather than a mental health agency. Chinese American families may follow this pattern. White families may be more likely to follow Type B patterns, whereby there is early use

of social and outpatient facilities, with inpatient treatment being a last resort. Type C was marked by early social and legal intervention by outside sources often against the desires of the family; a pattern characteristic of the experience of Native Americans.

Finally, various researchers have concluded that clinician bias may have much to do with the problems of mental health service utilization and the treatment outcomes for ALANA clients. Snowden and Chueng (1990) reported that African Americans were more likely to be diagnosed with psychotic disorders than affective disorders that are less stigmatizing and have more positive prognoses. On the other hand, Asian Americans may be under-diagnosed because of a perception of them as being "problem-free" (Takeuchi & Abe-Kim, 1996). Due to genetic difference in drug metabolism, many African and Asian Americans slowly metabolize trycyclics and selective serotonin reuptake inhibitors (SSRI), indicating that such clients should, if prescribed anti-depressants, be started on lower doses at the beginning of treatment. The opposite has been true, in that clinicians in psychiatric emergency services prescribed more oral doses and more injections of antipsychotic medications to such African American patients (Snowden, 1998a). The combination of slow metabolism and overmedication can lead to extremely uncomfortable side effects, which no doubt contributes to the mistrust of mental health services reported among such clients. (Sussman et al., 1987).

Cultural concerns with ALANA populations

The beliefs, values, attitudes, and behaviors of ALANA populations have a direct impact on their psychological functioning, concept of illness, expression of symptoms, and the responses received. Aponte and Johnson (2000) developed a schema for

considering the factors through which culture impacts their experience. The dominant culture influences the process of acculturation and nondominant culture, the process of enculturation, which in turn dually influence the ethnic and racial identity. This identity, along with other social identities of gender, age, sexual orientation, SES, religion, and the presence or absence of a disability, create a framework for the person's functioning and symptom presentation. There are moderator variables of sociopolitical history of the acculturating group, oppression and legal constraints, language usage and fluency, as well as individual characteristics that then affect the service utilization, the treatment process, and the outcome of counseling. Consistent with this schema, in the next section of this literature review, I will provide an overview of acculturation theory with reference to specific ALANA groups, and then cover racial identity development theory.

Acculturation and Enculturation. Acculturation occurs as a person responds to the influence of the dominant or second culture, while enculturation denotes the processes by which a person is socialized into his or her primary culture. Transmission of cultural knowledge, awareness, and values occur from a number of sources including one's families, peers, and "own-group" institutions (Berry & Kim, 1988). In a society like the US, where European American culture is dominant, these enculturation experiences of ALANA groups are often in conflict with the dominant culture influences and messages. Some recent immigrants have been brought up in their own cultural group which consists of the larger society and then been moved to having their culture be a non-dominant sub-group in US society. Alternatively, African Americans who are generational offspring of enslaved Africans, have maintained a subculture within the European American dominated society which retains defined characteristics of its own. If

a person has a successful enculturation experience, he or she can function effectively within the cultural group of origin. The degree to which one is enculturated may affect the manner in which one responds to acculturation. The pressure of acculturation may reverse or change the degree of enculturation (Casas & Pytluk, 1995).

Marin (1992) developed a psychosocial definition of acculturation as a process of attitudinal and behavioral change, undergone willingly or unwillingly, by individuals who reside in multicultural societies or who come into contact with a new culture through immigration, colonization, or other political changes. The three levels of attitudinal and behavioral learning start with the *superficial* one which consists of learning facts and history of the dominant culture and forgetting facts about one's culture of origin. At the *intermediate* level, changes take place in the more central behaviors in a person's life such as language preferences and use, ethnicity of friends, neighbors, spouse or preferences for names given to children. The third level of *significance* involves changes that take place in the individual's beliefs, values, and norms that describe the person's worldview and interaction patterns (Marín, 1992).

The four modes of acculturation are theorized to be assimilation, separation, marginalization, and integration, with each mode associated with a different set of stressors, social and psychological issues (Berry & Kim, 1988). *Assimilation* denotes a shift towards the dominant culture together with a rejection of one's culture of origin, with a goal to complete absorption and acceptance by the dominant culture. Such cases run the risk of rejection by families and communities as well as lack of acceptance by the dominant culture, and may therefore experience high levels of anxiety and low self-esteem (LaFrombaise, Coleman, & Gerton, 1993). In contrast, the *separation* mode

describes those who retain their cultural values and identity while rejecting those of the dominant culture. These individuals may be effective in their own communities, but may not be able to negotiate the dominant culture and powerful systems, often turning to indigenous social supports and health care. (Koss-Chioino, 2000). *Marginalization* involves a rejection of both the culture of origin as well as the dominant culture, and such individuals have difficulty with social functioning and acceptance, and may lack a sense of cultural identity and self-efficacy. Finally, the *integration* mode also referred to as *biculturalism* involves a flexible balancing of some dominant culture attitudes and practices with retention of culture of origin cultural practices and identity. These individuals have a wider behavioral repertoire that brings effectiveness across varying cultural contexts, a sense of belonging to both cultures, and maintain an integrated cultural identity (LaFrombaise, Coleman, & Gerton, 1993),

Ethnic and racial identity development. Ethnic/racial identity is a construct referring to an individual's awareness and sense of self as a racial, ethnic, and cultural being. Ethnic and racial identity development describes the process by which individuals become aware of, ascribe meaning to, and integrate racial and cultural information into their overall self-concept (Aponte & Johnson, 2000). The first models were made primarily by social scientistss such as Cross, Jackson, and Thomas, and focused solely on African American identity development. These models tended to focus on race, and strove to provide a way to assess the attitudinal impact on the overall psychological development of African Americans (Casas & Pytluk, 1995). More recent models have been updates and developed to include identity development processes among Latinos (Bernal & Knight, 1993), Whites (Helms, 1995), Chicanos (Ruiz, 1990) and biracial

groups (Poston, 1990). Models such as the Minority Identity Development Model (Atkinson et al., 1998) and the People of Color Racial Identity Model (Helms, 1995) are applicable across ALANA groups. Essentially, most models describe a movement from a stage of lack of awareness of cultural, ethnic, racial identity and low salience for race and ethnicity in terms of self-concept (Helms, 1995), through a change event that forcibly brings the person into dissonance with such a self-concept, going through a immersive identification with the ethnic/ racial group of origin, with final stages of a flexible, internalized, sense of self that acknowledges cultural identity but also incorporates other identities (Atkinson et al., 1998). These models, while purporting not to be linear, end up being stage models that imply general dysfunction in earlier levels of stress and anxiety, followed by transitional stressors and rigidity in middle sections, with final stages implying serenity and high self-efficacy.

Acculturation and ethnic/racial identity are complex and multidimensional processes that are considered central to understanding the mental health needs of ALANA populations (Aponte and Johnson, 2000). These constructs interact with and are influenced by factors such as socioeconomic status; residence both in terms of length of time in the U.S. as well as the ethnic density of the surrounding community; racism and oppression; worldview, language usage, and religious and spiritual beliefs; as well as gender and familial and social support structures (Aponte and Johnson, 2000). Carter, Sbrocco, and Carter (1996) provide a framework for examining the interactive effects of acculturation status and ethnic identity in terms of beliefs about psychological issues, symptoms experienced, as well as help-seeking, expectations, and treatment outcomes.

The counseling relationship

The counseling relationship is the arena where the experiences of ALANA clients play out, and is a central construct in the process of intervention and treatment. While counselors cannot do much about the cultural values that shape the help-seeking behaviors of ALANA clients, they are very much part of the processes by which clients decide where counseling is a viable option, whether the experience is positive and growth-producing, or toxic and stultifying. Lazarus (1992, in Corey, 1996), founder of the cognitive-behaviorally based multimodal therapy, described the client-counselor relationship as the soil that enables the counselor's techniques to take root. Sexton and Whiston (1994), in their empirical review of the literature on the counseling relationship, offer an operational definition that, "the counseling relationship is those aspects of the client and counselor and their interaction that contribute to a therapeutic environment, which in turn may influence client change" (p.8). This definition implies that the client and counselor are different kinds of participants in the interaction, that there is a particular kind of therapeutic space in which relationship is created, and that the relationship is linked to both process and outcome. Unfortunately, most of the literature does not focus on multicultural clients, and there is little research done specifically on the development and maintenance of the counseling relationship with such clients. There is even less literature that looks at the counseling relationship specifically from the client's perspective. However, the importance of the construct demands a brief overview, and then an exploration of the available research on multicultural clients.

The three major ways in which the counseling relationship has been conceptualized consist of a focus on issues of transference and countertransference,

drawn primarily from psychoanalytic traditions; the authenticity of the relationship, based on the humanistic traditions of client-centered counseling; and finally, the construct of the working alliance (Gelso & Carter, 1994).

Transference and Countertransference. The transference configuration or the "unreal" relationship (Gelso & Carter, 1985), is embedded in psychoanalytic theory, most significantly Freud's The Dynamics of Transference (1912, in Horvath & Luborsky, 1993), and includes the client transference and the counselor countertransference. This is probably the earliest elaborated perspective on the counseling relationship. Transference became the central feature of psychoanalysis, in that interpreting transferential material was the path to successful psychoanalytic treatment. Countertransference, in turn, consists of the counselor's distorted reaction to the client. Lang (1974) defined countertransference as one aspect of those responses to the client which are primarily based on the counselor's past significant relationships and are basically gratifying the counselor's needs rather than the client's counseling endeavor. Luborsky and Crits-Christoph (1989, in Sexton & Whiston, 1994) proposed that the transference configuration might be more broadly conceived as a central script that each person follows in conducting relationships.

The authentic relationship. The next major focus on the importance of relationship was through the work of Rogers (1957), the founder of person-centered counseling, whose theoretical propositions generated decades of research into the facilitative conditions that he postulated as necessary and sufficient for positive therapeutic outcome. The humanistic theories of counseling appear to construct the counseling relationship as a relationship that derives from therapist authenticity,

congruence, and openness. To the extent that the counselor is able and willing to be open about his or her feelings, a real relationship exists. Rogers (1961) stated bluntly that, "If I can provide a certain type of relationship, the other person will discover within himself or herself the capacity to use that relationship for growth and change, and personal development will occur" (p.33).

Much of the theory and research about relationship came out of the client-centered tradition (Carkhuff & Berenson, 1967; Patterson, 1978; Truax & Cardhuff, 1967; in Gelso & Carter, 1985) of the conditions of empathic understanding, congruence, and unconditional positive regard. It is notable that a perspective so centered on relationship has focused almost all its efforts on only one side of it, that is, the counselor-offered conditions. Given that caveat, there is a plethora of rigorous and controlled studies that offer a great deal of data on the authentic relationship. Gelso and Carter (1985) reviewed the two decades of literature that came out of the conditions originally specified by Rogers (1957) and concluded that the conditions of empathy, unconditional positive regard, and congruence were obviously facilitative for effective counseling. Given the strong evidence that facilitative conditions were positively related to outcome, a number of studies used the facilitative conditions as operational definitions of good counseling relationships (Sexton & Whiston, 1994).

The Working Alliance. The most popular conception of the counseling relationship currently is in the form of the working or therapeutic alliance, defined by Bordin (1975) as consisting of three parts: an emotional bond between participants, an agreement on the goals of counseling, and an agreement of the tasks of counseling. Therefore the association between counselor and client is marked by emotional warmth

of mutual liking, trust, and respect, and characterized by common agreement on the process, structure, and outcome of counseling.

There has been much research done on a variety of client factors and their influence on the development of the working analysis. To organize the research findings, Horvath and Luborsky (1993) sorted them out into the three categories of interpersonal capacities or skills, intrapersonal dynamics, and diagnostic features. Unfortunately, the ethnicity or the cultural characteristics of the client were not part of their analysis. Indeed, this issue is not mentioned in most of the literature, unless specifically dealing with a multicultural population. While gender and race/ethnicity are often reported in most recent studies as demographic variables, few consider them as comparison variables (McRae & Noumair, 1997).

Ethnicity and the counseling relationship

Investigations into the effects of ethnicity on the counseling relationship appear to be in one of three areas: client help seeking and problem perception, the client expectancies, preferences, and perceptions of the counselor, and the ways in which the counselor's ethnic identity affect the client's perceptions of the counseling relationship. Many of the studies appear to focus on understanding the underutlization of mental health services by ALANA clients in terms of whether such low relative rates are based on psychological services not being considered credible help sources, whether it is based on the culturally unresponsive services offered, or whether the cultural values are incompatible with the values inherent in the mental health system (Ponce and Atkinson, 1989).

In seeking to understand the reasons that Asian Americans underutilize counseling services, Tracey, Leong, and Glidden (1986) theorized that the emphasis on family and preserving face imply that using psychological services would be a public admission of problems, which would be a drastic measure of help seeking. However, they also theorized that when such clients did appear they would present differently from White clients. In studying problem perceptions between Asian American and White clients, moderated by both client gender and previous counseling experience, they generated some interesting results. They found that while White clients were far more willing to express personal and emotionally based concerns, Asian Americans were more likely to perceive themselves as having educational or vocational concerns. Gender impacted these results in that the most number of problems were perceived by Asian American women, followed by White women, White men, and lastly, Asian American men. Previous counseling experience had no effect on the problem definition by Asian Americans, though it was related to White clients being more likely to endorse personal and emotional concerns as problems. Within group differences were most predominant with Filipino Americans and bicultural Asian and White clients being more willing to express personal and emotional concerns relative to the other Asian American clients.

Sanchez and Atkinson (1983) found that strong commitment to Mexican American culture was positively related to preferences for an ethnically similar counselor, as well as negatively related to willingness to self-disclose in counseling. Gender was also a variable in these results, with women being more willing to use professional counseling services. In examining Mexican American perceptions of and willingness to see a counselor, Ponce and Atkinson (1989) used a factorial design to

incorporate the effects of three levels of acculturation, two levels of counselor ethnicity, and two levels of directive and nondirective counseling style. Acculturation appeared to have no effect for any dependent variable, but higher credibility ratings were given to Mexican American counselors as opposed to White counselors, together with greater willingness to see ethnically similar counselors for personal, academic and vocational concerns. Additionally, more positive ratings were given to directive counseling styles as opposed to nondirective styles. A recent study on Mexican American college students and their counseling expectations based on counselor ethnicity by Abreu (2000), resulted in similar findings. In a similar vein, Okonji (1996) found that male African American participants gave significantly higher ratings to videotaped vignettes depicting African American counselors over European American counselors, and reality therapy got higher ratings from participants then did person-centered therapy.

In a an early study, Carkhuff and Pierce (1967, in Leong, Wagner, & Tata, 1995) found that those counselors who were most different from their clients in terms of race/ethnicity and social class had the most difficult time with initiating and maintaining effective exploration with their clients. Sattler (1977, in Leong, Wagner, & Tata, 1995), in a review of such studies of ethnic preference, noted that other things being equal, African American clients preferred African American counselors. However, a competent European American professional would be preferred to a less competent African American professional. Pointing out that most of these studies of African American counselor preferences used a confirmatory hypothesis-testing strategy that would then either affirm or withhold judgment on such a preference, Ponterotto, Alexander and Hinkston (1988) used a disconfirmatory hypothesis-testing strategy. They found that in

weighing relative counselor preferences among African Americans, ethnically similar counselors were significantly preferred, with preferences for a counselor with similar attitudes and values being the second highest preference. Atkinson, Furlong and Poston (1986) also found that while African American students preferred an ethnically similar counselor over an ethnically dissimilar counselor, they also preferred counselors with similar attitudes and personalities, who were older and more educated over a counselor of the same ethnicity.

In a meta-analysis of studies that assessed ethnic minorities' (people of African, Latino, Asian, and Native American heritage) perceptions of and preferences for ethnically similar versus European American counselors, Coleman, Wampold, and Casali (1995) found that the matter was far more complex. It appeared that rather than the race/ethnicity of the client predicting the type of decisions he or she would make about the counselor, it was the person's stage or state of ethnic identity development, acculturation, or cultural commitment that exerted the major influence. They hypothesized that, given that relationships are determined by perceived commonality of attitudes and values, certain variables considered demographic such as race/ethnicity or gender, are important because they convey information about attitudes and values. So, in lieu of other information, in the initial stages of the counseling relationship, clients may make inferences about the attitudes, values, and skills, of the counselor based on such demographic variables. One hypothesis regarding such inferences is that they may be realistic. One of the important points they raise is that non-matching of client and counselor on ethnic similarity has sometimes lead to premature termination or unsuccessful outcome. On the other hand, while ethnic match between client and

counselor resulted in substantially lower odds of dropping out than for unmatched clients, there is little data on whether client preference for ethnically similar counselors is linked to effective outcome.

Studies that focus on aspects of identity other than ethnicity seem to show similar preferences for similarity among clients. Leirer (1996) examined the influence of the counselor's disability status, disability relevance of counseling content, and counselor attending behavior, on participants' perceptions of counselors. University students with disabilities viewed vignettes and rated the counselor performance in terms of perceived counselor effectiveness. Results indicated that given a high disability content of counseling and high attending behaviors, counselors with disabilities may have a small advantage over other counselors when counseling disabled clients. In a study of lesbian and gay client perceptions of counselor helpfulness, Liddle (1996) found that clients rated gay, lesbian, and bisexual counselors as more helpful than heterosexual counselors. Heterosexual female counselors were rated more helpful by clients of both genders when contrasted to heterosexual male counselors. According to these studies, client-counselor matching, especially on the dimensions of social identity that are characterized by special experience as well as knowledge, does appear to increase the strength of the counseling relationship, as well as influence outcome through discouraging premature termination.

However, what seems to be even more important than simple attributes is the meaning that clients and counselors give to those attributes and how they are attended to. Terell and Terell (1984, in Thompson, Worthington, and Atkinson, 1994) found that cultural mistrust (defined as a survivalist posture assumed to endure racism) among African Americans was linked to premature termination with European American

counselors, differential preferences for a African American or European American counselor, and differential expectations of counselors from either group. Levels of cultural mistrust were positively correlated with levels of premature termination regardless of counselor ethnic identity. As well, DeHeer, Wampold, and Freund (1992, in Coleman, Wampold, & Casali, 1995), in a test of preferences related to the gender of the counselor, found that when given available information about competency, potential clients would prefer a competent counselor regardless of gender. Robiner and Storandt (1983) found that client perceptions of the counseling relationship were not necessarily affected by either client age or counselor age. Age similarity between the client and counselor did not necessarily improve the working alliance.

Clients are of course not the only actors in the relationship, and the actions of the counselor with regard to attending to such variables have been found to make a difference. Thompson, Worthington, and Atkinson (1994) investigated the effects of African American and European American counselors' addressing of the client's culture in counseling with African American women clients. They found a significant positive relationship between the counselor's addressing of culture with the client's depth of self-disclosure. There appeared to be a three-way interaction between the client's level of cultural mistrust, the counselor's ethnicity, and the counselor's addressing of cultural issues. Highly mistrustful clients disclosed more to African American counselors who addressed culture, while clients with low-levels of cultural mistrust were more self-disclosing with counselors of either African American or European American ethnicity who addressed culture in counseling.

Given decades of attention to such issues in the counseling profession, to greater or lesser degree, there is little data on the experiences of clients. By and large, the method of determining issues in counseling has been from a positivist, quantitative perspective. While clients' behavioral or psychological change may be measured to check effectiveness, their interactions analyzed, or their opinions sought on certain researcher-generated constructs, their narratives of the experience and meaning of counseling are generally unheard. In a rare exception, Batchelor (1995) performed a study of client perceptions of the therapeutic alliance, using a standard, open-ended self-report inquiry format. This semi-qualitative study only had European Americans as client subjects, but gathered intriguing information about three major themes that were meaningful. Nurturant-type alliances were seen as conducive to client self-disclosure, insight-oriented alliances were characterized by improved client self-understanding, and collaborative alliances were centered on the client's involvement in the work of therapy. Interestingly, different clients perceived a positive therapeutic alliance differently, attaching significance to different components. Instead of alliance being based solely on counselor or client factors, it appeared to be a complex interaction of both in a climate the client perceived as positive.

Conclusion

In concluding their review of the counseling relationship literature, Sexton and Whiston (1994) suggested that the modernist approach in counseling is flawed since this approach is blind to the cultural conditions in which psychological processes are conducted. According to Gergen (1991), the nature of knowledge and generation of meaning is both contextually bound and socially based. The primary location of

psychological processes is therefore in the social world of interaction rather than the intrapsychic world of the individual. Conceptualizing the counseling relationship as an interaction is not a novel idea. However, the notion that the interactional patterns only gain meaning in the context of the relationship and the broader historical, social, and cultural context is distinctly new. This stance implies that striving to identify the causal structures of the relationship is irrelevant if not impossible, since the study of meaning is more central.

From a social constructivist perspective, the counseling relationship would be a dynamically evolving behavioral, cognitive, and verbal interaction that emerges through language and discussion. For Gergen (1991), meaning is developed in relationships by the ways in which language is used to co-construct explanations of self, others, and events. Since the basic premise of this paradigm is that meaning is co-constructed, the role of language is crucial in this context of social interaction.

In the counseling relationship, how the relationship is perceived, what importance it holds, its influence on the outcome of counseling, is all developed through the discourse of the participants. The social influence of the counselor, the transferential issues of the client, the counselor congruence, or the client's ethnic preference, are all dependent on how the counselor and client have constructed the importance and particular meanings of such variables. According to White and Epston (1990), therapeutic dialogue, which implies interaction, rewrites the client's narrative to produce new meanings thereby resulting in new cognitive and affective experiences.

The literature reviewed here testifies to the interest in understanding cultural and ethnic factors in providing appropriate mental health services. Each of the major

organizations such as the American Counselors Association and the American Psychological Association have developed guidelines and ethnical principles that address these issues (ACA, 1995; APA, 1993). There is a recognition in these principles that we need to recognize diversity, understand the role that culture and ethnicity play in sociopsychological development, understand the factors that significantly impact such development as well as the interaction of culture, gender, and sexual orientation on behavior and needs, so as to be able to help clients understand, maintain, and/or resolve their own sociocultural identification (APA, 1993). However, despite the call to the profession, put forward by Sue, Arredondo, and McDavis (1992), advocating specific multicultural counseling competencies and standards, the majority of counselors working today appear to have little formal preparation for working with these issues either in their training programs or in their daily lives (Aponte & Aponte, 2000). The literature reviewed here demonstrates that as a profession, counselors have a long way to go in research, assessment, treatment, intervention and conceptualization of multicultural clients.

References

Abreu, J. M. (2000). Counseling expectations among Mexican American college students: The role of counselor ethnicity. *Journal of Multicultural Counseling & Development, 28*(3), 130-143.

American Counseling Association (1995). *Code of Ethics and Standards of Practice*. Alexandria, VA: American Counseling Association.

American Psychological Association (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist, 48*, 45-48.

Aponte, J. F. & Crouch, R.,T. (2000). The changing ethnic profile of the united States in the twenty-first century. In J. F. Aponte and J. Wohl (Eds.) *Psychological intervention and cultural diversity* (pp. 1-17). Needham Heights, MA: Allyn & Bacon.

Aponte, J. F. & Aponte, C. E. (2000). Educating and training professionals to work with ethnic populations in the twenty-first century. In J. F. Aponte and J. Wohl (Eds.) *Psychological intervention and cultural diversity* (pp. 250-267). Needham Heights, MA: Allyn & Bacon.

Aponte, J. F. & Johnson, L. R. (2000). The impact of culture on the intervention and treatment of ethnic populations. In J. A. Aponte and J. Wohl (Eds.) *Psychological intervention and cultural diversity*. Needham Heights, MA: Allyn & Bacon.

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. *The Counseling Psychologist, 11*, 79-92.

Atkinson, D. R., Morten, G., & Sue, D. W. (1993) *Counseling American Minorities*. (4th Edition). Dubuque, IA: Brown.

Atkinson, D. R. , Furlong, M. J. , & Poston, W. C. (1986). Afro-American preferences for counselor characteristics. *Journal of Counseling Psychology, 33*(3), 326-330.

Batchelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology, 42*(3), 323-337.

Bernal, M. & Castro, F. (1994). Are clinical psychologists prepared fro service and research with ethnic minorities? American Psychologist, 47, 797-805.

Berry, J. W. & Kim, U. (1988). Acculturation and mental health. In P. R. Dasen, J. W. Berry, and N. Sartorius (Eds.). *Health and cross-cultural psychology: Towards applications* (pp. 207-236). Newbury Park, CA; Sage.

Bordin, E. S. (1975). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice, 16*, 252-260.

Brown, B. S., Joe, G. W., & Thomson, P. (1985). Minority group status and treatment retention. *International Journal of the Addictions, 20*, 319-335.

Carter, R. T., Sbrocco, C., & Carter, T. (1996). African Americans and anxiety disorders research: Development of a testable, theoretical framework. *Psychotherapy, 33*, 449-463.

Casas, J. M. & Pytluk, S. D. (1995). Hispanic identity development: Implications for research and practice. In J. G. Ponterotto, J. M. Casas, L. Suzuki, & C. M. Alexander, (Eds.).(1995). *Handbook of Multicultural Counseling (pp. 155-180).* Thousand Oaks, CA: Sage.

Coleman, H, L. K., Wampold, B. E., and Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European American counselors: A meta-analysis. *Journal of Counseling psychology, 42*(1), 55-64.

Corey, G. (1996). *Theory and practice of counseling and psychotherapy (5th Ed.).* Pacific Grove, CA: Brooks/Cole.

D'Andrea, M. (1995). Promoting multiculturalism and organizational change in the counseling profession. In J. G. Ponterotto, J. M. Casas, L. Suzuki, & C. M. Alexander, (Eds.). (1995). *Handbook of Multicultural Counseling (pp. 17-33).* Thousand Oaks, CA: Sage.

Draguns, J. G. (2000). Psychopathology and ethnicity. In J. A. Aponte and J. Wohl (Eds.) *Psychological intervention and cultural diversity.* Needham Heights, MA: Allyn & Bacon.

Gelso, C. J. & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*(3), 296-306.

Gelso, C. J. & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist, 2,* 155-243.

Gergen, K. (1991). *The saturated self.* New York: Basic Books.

Helms, J. E. & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process.* Needham Heights, MA: Allyn & Bacon.

Helms, J. E. (1995). *Black and White Racial identity: Theory, Research, and Practice.* Westport, CT: Greenwood Press.

Herring, R. D. (1999). *Counseling with Native American Indians and Alaska Natives: Strategies for helping professionals.* Multicultural Aspects of Counseling Series 14. Thousand Oaks, CA: Sage.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 16*(4), 561-573.

Indian Health Service (1998). *A progress report on Indian alcoholism activities.* Rockville, MD: US Department of Health and Human Services, Public Health Service.

Ivey, A. E. .(1995). Psychotherapy as liberation: Toward specific skills and strategies in multicultural counseling and therapy. . In J. G. Ponterotto, J. M. Casas, L. Suzuki, & C. M. Alexander, (Eds.).(1995). *Handbook of Multicultural Counseling (pp. 53-72).* Thousand Oaks, CA: Sage.

Jimenez, N. E. (1997). Health behavior as a function of gender and acculturation among Mexican and Mexican American adults. (Doctoral Dissertation, California School of Professional Psychology, Los Angeles, 1997). *Dissertation Abstracts International,* 58(3-B), 95017-348.

Keith, S. J., Regier, D. A., & Rae, D. S. (1991). Schizophrenic disorders. In L.N. Robins and D. A. Regier (Eds.) *Psychiatric Disorders in America: The epidemiologic catchments area study.* New York: Maxwell Macmillan International.

Kinzie, J. D. & Leung, P. (19989). Clonidine in Cambodian patients with post-traumatic stress disorder. *Journal of Nervous and Mental Disease, 177,* 546-550.

Koss-Chioino, J. D. (2000). Traditional and folk approaches among ethnic minorities. In J. F. Aponte and J. Wohl (Eds.) *Psychological intervention and cultural diversity (pp. 149-166)*. Needham Heights, MA: Allyn & Bacon.

Korchin, S. J. (1980). Clinical psychology and minority problems. *American Psychologist, 35*, 262-269.

Kurasaki, K., Sue, S., Chun, C. & Gee, K. (2000). Ethnic minority treatment and intervention research. In J. A. Aponte and J. Wohl (Eds.) *Psychological intervention and cultural diversity*. Needham Heights, MA: Allyn & Bacon.

Lang, R. L. (1974). *The technique of psychoanalytic psychotherapy, Vol. II*. New York: Jason Aronson.

Lee, S. M. (1998). Asian Americans: Diverse and growing. *Population Bulletin, 53*(2), 1-40.

Leirer, S. J. (1996). The effect of counselor disability, attending behavior, and client problem on counseling. *Rehabilitation Counseling Bulletin, 40*(2), 82-95.

Leong, F. T., Wagner, N. S., & Tata, S. P. (1995). Racial and ethnic variations in help-seeking attitudes. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, and C. M. Alexander (Eds.) *Handbook of Multicultural Counseling. (415-438)*, Thousand Oaks, CA: Sage Publications.

Liddle, B. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings of helpfulness by gay and lesbian clients. *Journal of Counseling Psychology, 43*(4), 394-401.

Lopez, S. R., Lopez, A. A., & Fong, K. T. (1991). Mexican Americans' initial preferences for counselors: The role of ethnic factors. *Journal of Counseling Psychology, 27*, 71-75.

Manderscheid, R. W. & Sonnenschein, M. A. (Eds.). (1990). *Mental Health, United States, 1990. National Institute of Mental Health. DHHS Pub. (ADM) 90-1708.* Washington, DC: US Government Printing Office.

Marín, G. (1992). Issues in the measurement of acculturation among Hispanics. In K. E. Geisinger (Ed.) *Psychological testing of Hispanics (pp. 235-251).* Washington, D.C.: American Psychological Association.

McRae, M. B. & Noumair, D. A. (1997). Race and gender in group research. *African American Research Perspectives, 3*(2), 68-74.

National Center for Health Statistics (1991). *Vital and health statistics. Family structure and children's health: United States, 1988.* Washington, D.C.: U.S. Government Printing Office.

O'Hare, W. P. (1992). America's minorities—the demographics of diversity. *Population Bulletin, 47*(4), 1-47.

Okonji, J. M. (1996). Preferred style and ethnicity of counselors by African American males. *Journal of Black Psychology, 22*(3), 329-339.

Patterson, C.H. (1978). Cross-cultural or intercultural counseling. *Hacettepe University Bulletin of Social Sciences*, 119-134.

Ponce, F. Q. & Atkinson, D. R. (1989). Mexican-American acculturation, counselor ethnicity, counseling style, and perceived counselor credibility. *Journal of Counseling Psychology, 36*(2), 203-208.

Ponterotto, J. G. & Casas, M. J. (1991). *Handbook of racial/ethnic minority counseling research*. Springfield, IL: Charles C Thomas.

Ponterotto, J. G., Casas, J. M., Suzuki, L., & Alexander, C. M. (Eds.).(1995). *Handbook of Multicultural Counseling*. Thousand Oaks, CA: Sage.

Ponterotto, J. G., Alexander, C. M., & Hinkston, J. A. (1988). Afro-American preferences for counselor characteristics: A replication and extension. *Journal of Counseling Psychology, 35*,(2), 175-182.

Poston, W. S. (1990), The biracial identity development model: A needed addition. *Journal of Counseling and Development, 69*, 152-155.

Priest, R. (1991). Racism and prejudice as negative impacts on African American clients in therapy. *Journal of Counseling & Development, 70*, 213-215.

Query, J. M. (1985). Comparative admissions and follow-up study of American Indians and Whites in a youth chemical dependency unit on the North Central Plains. *International Journal of the Addictions, 20*, 489-502.

Regier, D. A. (1993). The linkages of health care reform and health services research. *The American Journal of Psychiatry, 150*(11), 1613.

Robiner, W. N. & Storandt, M. (1983). Client perceptions of the therapeutic relationship as a function of client and counselor age. *Journal of Counseling Psychology, 30*(1), 96-99.

Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research.* Malabar, FL: Krieger.

Sanchez, A. R. & Atkinson, D. R. (1983). Mexican-American cultural commitment, preference for counselor ethnicity, and willingness to use counseling. *Journal of Counseling Psychology, 30*(2), 215-220.

Sexton, T. L. & Whiston, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist, 22*(1), 6-78.

Snowden, L. R. (1998). Managed care and ethnic minority populations. *Administration & Policy in Mental Health, 25*(6), 581-592.

Snowden, L. R. (1998). Racial differences in informal help seeking for mental health problems. *Journal of Community Psychology, 26*(5), 429-438.

Snowden, L. R. & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *The American Psychologist, 45*, 347-355.

Sue, D. W. (1981). *Counseling the culturally different: Theory and practice.* New York: John Wiley and Sons.

Sue, D. W. & Sue, D. (1999). *Counseling the culturally different: Theory and practice.* (3rd Edition). New York: John Wiley.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. Bergin and S. L. Garfield (Eds.). *Handbook of psychotherapy and behavior change (4th ed., pp. 783-817).* New York: Wiley.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70,* 477-486.

Sussman, L. K. Robins, L. N., & Earls, F. (1987). Treatment seeking for depression by Black and White Americans. *Social Science & Medicine, 24*(3), 187-196.

Takeuchi, D. T. & Abe-Kim, J. S. (1996). Cultural competence and quality of care: Issues for mental health service delivery in managed care. *Clinical Psychology Science & Practice, 3*(4), 273-295.

Thompson, C. E. , Worthington, R., and Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures, *Journal of Counseling Psychology, 41*(2), 155-161.

Tracey, T. J. & Leong, F. T. (1986). Help seeking and problem perception among Asian Americans. *Journal of Counseling Psychology, 33*(3), 331-336.

Turner, C. B. & Kramer, B. M. (1995). Connections between racism and mental health. In C. W. Willie, P. P. Rieker, B. M. Kramer & B. S. Brown (Eds.). *Mental health, racism, and sexism.* Pittsburgh, PA: University of Pittsburgh press.

U.S. Bureau of Census (1997). Current population reports: Special studies, P23-193. Washington, D.C.: U.S. Government Printing Office.

Vega, W. A., & Murphy, J. W. (1990). *Culture and the restructuring of community mental health.* New York: Greenwood Press.

Watkins, C. E. Jr. & Terrell, F. (1988). Mistrust level and its effects on counseling expectations in Black client-White counselor relationships: An analogue study. *Journal of Counseling Psychology, 35,* 194-197.

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